Checklist of Items
To be included in Grievance and Appeals Section
of a Limited Health Services Benefit Plan

In accordance with KRS 304.17A-605 section 1 (1), a Limited Health Services Organization (LHSO) is subject to KRS 304.17A-600, 304.17A-603, 304.17A-605, 304.17A –607, 304.17A-609, 304.17A-611, 304.17A-613, and 304.17A-615. The Limited Health Services Benefit Plan must include a:

( ) 1. Disclosure of the right to an internal appeal of a utilization review (UR) decision made by or on behalf of the insurer with respect to the denial, reduction, or termination of a limited health service benefit plan or the denial of payment for a health care service, and the procedure to initiate an internal appeal – KRS 304.17C-030 (2)(g)(2).

In disclosing the availability of an internal appeal process to an enrollee, other information relating to the internal appeal process may be disclosed. In this situation, the DOI should review the disclosure and prohibit any language which may conflict with 806 KAR 17:280, which states that:

( ) The internal appeals process may be initiated by the enrollee, an authorized person, or a provider acting on behalf of the enrollee;
( ) An enrollee, authorized person, or provider acting on behalf of an enrollee must be given at least 60 days from the receipt of a notice of an adverse determination or a coverage denial in which to file a request for an internal appeal; and
( ) The internal appeal decision must be provided within thirty (30) days.